

Centers for Medicare & Medicaid Services, HHS

§ 434.63

under section 1915(b) of the Act prior to January 1, 1986, is exempt from those requirements relating to composition of enrollment and disenrollment without cause in §§ 434.26 and 434.27(b), during the effective period of the waiver, including extensions and renewals.

[55 FR 51295, Dec. 13, 1990, as amended at 61 FR 69050, Dec. 31, 1996]

EFFECTIVE DATE NOTE: At 66 FR 6403, Jan. 19, 2001, § 434.44 was removed, effective April 19, 2001. At 66 FR 11546, Feb. 26, 2001 the effective date was delayed until June 18, 2001, at 66 FR 32776, June 18, 2001 it was furthered delayed until Aug. 17, 2001, and at 66 FR 43090, Aug. 17, 2001 it was furthered delayed until Aug. 16, 2002.

Subpart E—Contracts with HMOs and PHPs: Medicaid Agency Responsibilities

SOURCE: 48 FR 54020, Nov. 20, 1983, unless otherwise noted. Redesignated at 55 FR 51295, Dec. 13, 1990.

EFFECTIVE DATE NOTE: At 66 FR 6403, Jan. 19, 2001, subpart E consisting of §§ 434.50 through 434.67 was removed and reserved, effective April 19, 2001. At 66 FR 11546, Feb. 26, 2001 the effective date was delayed until June 18, 2001, at 66 FR 32776, June 18, 2001 it was furthered delayed until Aug. 17, 2001, and at 66 FR 43090, Aug. 17, 2001 it was furthered delayed until Aug. 16, 2002.

§ 434.50 Proof of HMO or PHP capability.

The agency must obtain from each contractor proof of—

(a) Financial responsibility, including proof of adequate protection against insolvency; and

(b) The contractor's ability to provide the services under the contract efficiently, effectively, and economically.

[48 FR 54020, Nov. 30, 1983; 48 FR 55128, Dec. 9, 1983]

§ 434.52 Furnishing of required services.

The agency must obtain assurances from each contractor that—

(a) It furnishes the health services required by enrolled recipients as promptly as is appropriate; and

(b) The services meet the agency's quality standards.

§ 434.53 Periodic medical audits.

(a) The agency must establish a system of periodic medical audits to insure that each contractor furnishes quality and accessible health care to enrolled recipients.

(b) The system of periodic medical audits must—

(1) Provide for audits conducted at least once a year for each contractor;

(2) Identify and collect management data for use by medical audit personnel; and

(3) Provide that the data includes—

(i) Reasons for enrollment and termination; and

(ii) Use of services.

§ 434.57 Limit on payment to other providers.

The agency must ensure that, except as specified in § 434.30(b) for emergency services, no payment is made for services furnished by a provider other than the contractor, if the services were available under the contract.

§ 434.59 Continued service to recipients whose enrollment is terminated.

The agency must arrange for Medicaid services without delay for any recipient whose enrollment is terminated, unless it is terminated because of ineligibility for Medicaid.

§ 434.61 Computation of capitation fees.

The agency must determine that the capitation fees and any other payments provided for in the contract are computed on an actuarially sound basis.

§ 434.63 Monitoring procedures.

The agency must have procedures to do the following:

(a) Monitor enrollment and termination practices.

(b) Ensure proper implementation of the contractor's grievance procedures.

(c) Monitor for violations of the requirements specified in § 434.67 and the conditions necessary for FFP in contracts with HMOs specified in § 434.80.

[59 FR 36084, July 15, 1994]